Perspectives and Practice

Health and Popular Education in Latin America

Teresa Marshall & Lynda Yanz

Workshop Report - Montevideo, 1986

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CEAAL

International Council for Adult Education

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This is the testimony of an event that took place in Montevideo, Uruguay December lst and 5th, 1986. The workshop brought together more than 30 of us working in community health and popular education in different parts of Latin America. This meeting was convened by the Latin American Council for Adult Education (CEAAL) through its Health and Popular Education Network.

Participants came with different experiences, from Argentina, Brazil, Colombia, Chile, Ecuador, Mexico, Peru and Uruguay. Although we came from different places, with different practices and experiences, we had something important in common. All shared a passion for and were involved in a constant search to create popular alternatives for health care that would be capable of responding to the increasingly urgent local needs brought on by the deterioration of living conditions and the challenges of social and political change.

This is the testimony of a meeting of health professionals and popular educators. Each person contributed her or his knowledge and experience from a base in local practice, in urban slums, shantytowns or peasant communities. We worked together during three intensive days: opening a space where the convergence of curative and educational actions may be possible, trying to find the balance between advocacy and demands for basic rights and services; searching for how to combine collective political work with personal development.

The workshop was a moment of encounter. We started by recognizing and sharing our different practices. We ended by suggesting ways of extending this work towards the horizon of popular health in Latin America.

1.TALKING ABOUT HEALTH IN LATIN AMERICA

This chapter weaves together the debate that took place in the workshop with excerpts from reports presented by the participants. The analysis and debate centered on health as related to the quality of life. This allowed us to steer away from bio-medical arguments and instead to focus on alternative indicators. In order to discuss the causes of the problems and the different actions taken we had also to point to policies and actions at the macro social and political levels, the effect of state politicies, foreign dependency and, related to those, the erroneous mercantile-medical concept of health.

What is the problem?

The basic problem is the living conditions of the people, of the poor and underprivileged sectors in urban and rural areas. They are the ones who suffer most. It is impossible to maintain an acceptable level of health when people don't have sufficient food, shelter, and clothing... when hygiene, drinking water and sewage facilities are poor... when preventative and curative health care is sporadic and of a dubious quality.

People's living conditions have kept maternal, child and general mortality rates high, with the causes of death corresponding primarily to diseases that could be prevented or controlled. Mortality rates are higher in rural areas than in the urban sector, because of the general state of abandonment of the rural sector. *Ecuador - CESAP*.

The poor state of health in Veracruz is visible in people's living conditions. Houses have only 15 to 20 square meters consisting of a single room where people cook, eat and sleep. The great majority lack sanitary facilities, drinking water and electricity. Because of their low salaries, peasants rarely eat meat or fish. Their diet is restricted to beans, tortillas and chili. Occasionally they eat rice, eggs, or pasta soup. *Mexico, Veracruz*.

The country's health care system is so minimal that most of the population belongs to the "non-system". Only a small propor-

tion of the people (25 per cent) are ever seen by a doctor. This is even more actute for children under 5 years old. This makes it difficult to even obtain information regarding causes of death. *Peru, Piura - CIPCA.*

Health problems in marginal communities are closely related to living conditions. For example, after 10 years of agrarian reform the standard of living had increased, even though there had been no intervention of other factors or programs in health, school care, hygiene or housing. A permanent minimum salary plus small profits for good harvests, along with some improvements in services have been enough to raise health levels. *Peru, Piura - CIPCA.*

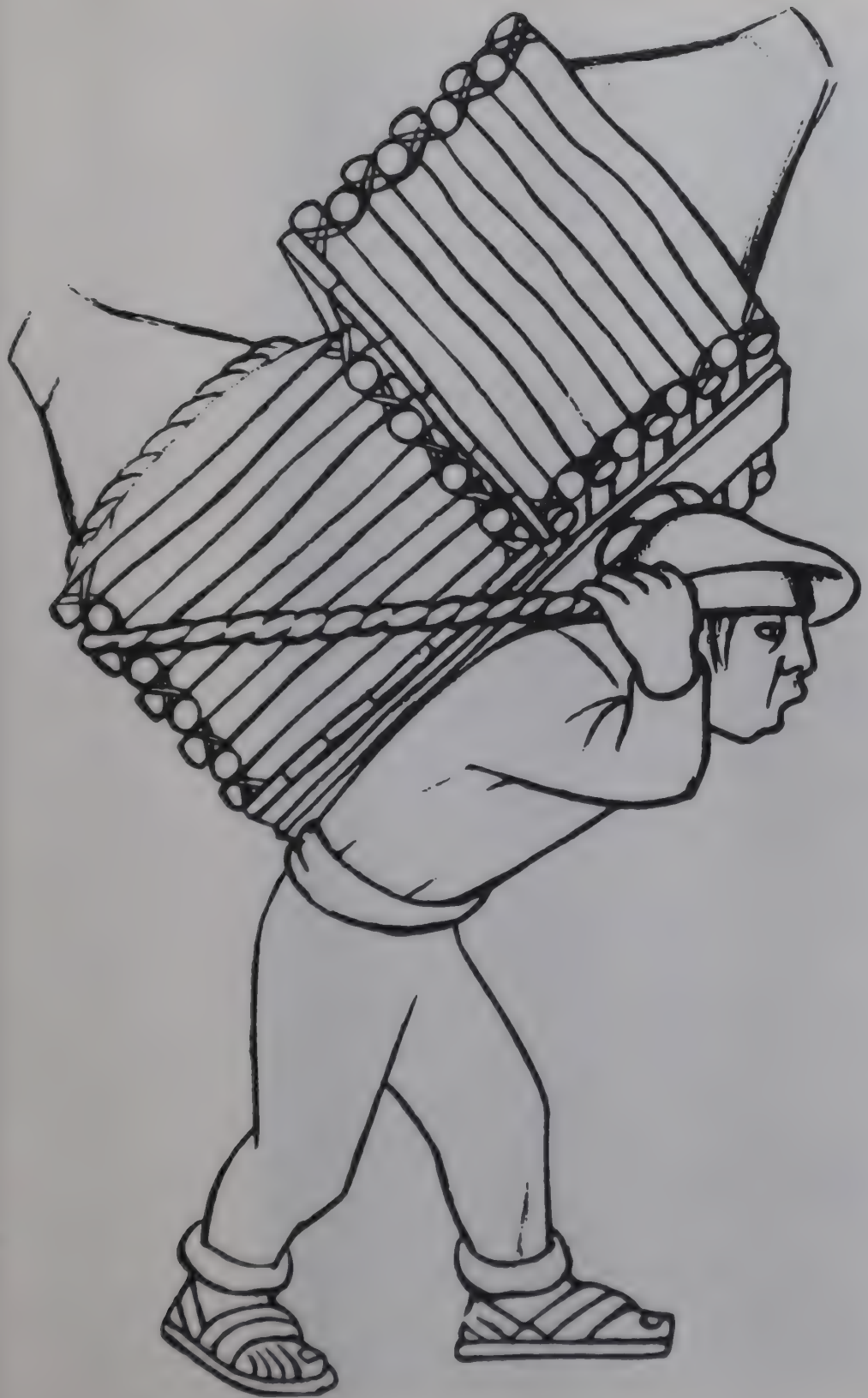
Mortality, life expectancy at birth, and malnutrition are key health indicators. It is interesting to look at and interpret these figures in a comparative way, not only between countries, but also to compare regional differences within countries, between cities, and between neighbourhoods. They reveal a panorama of inequality and insecurity and casts doubt on the existence of any universal right to health.

The child mortality rate for Peru is 100.2 per 1000 born alive, with the highest rates being in Puno (223.5), Huancavelica (209.3) and Moquegua (167.5). These figures widely surpass those for Latin America as a whole and are only lower than those of Bolivia and Haiti. These rates are closely related to poor conditions during pregnancy and delivery, and to the nutritional and environmental conditions in which Peruvian children live.

Recent data shows that 53.5 per cent of the population dies of infectious and exogenous diseases. Mortality rates due to contagious diseases have doubled in the last decade. Many of these (typhus, hepatitis and others) can be prevented by basic environmental sanitary actions, vaccination and improving the overcrowded conditions in which people are forced to live. *Peru, Lima - CIDEPSA.*

Within the 1 to 4 year-old group, the disease mortality pattern presents the following characteristics: deficient delivery care, poor environmental conditions, lack of timely medical care, and accidents at home and in the streets. *Colombia, Bogota - CINEP-NUTRIR.*

An analysis of the state of health in Region VIII shows that the situation is clearly unfavourable. There are different factors influencing this: rurality, low income levels, deterioration of economic activity within the region and high illiteracy rates. In Chile as a whole, child mortality reaches 21.9 per



1000 born alive. It is 17.2 in the metropolitan area and 31.8 in Region VIII. *Chile, Concepcion - INPRODE.*

There are marked differences in the state of health between regions and among different groups in the population. There is a difference of 30 years between the life expectancy at birth of a poor northeasterner and a rich southerner. Within the same city child mortality rates range from lower than 14 per 1000 born alive for some groups, up to 100/1000 for others. In the northeast it reaches 200/1000. Everywhere there is a paradoxical coexistence of "poverty diseases" and "modern diseases" (cancer, cardiovascular, etc.). The former are related to nutritional, housing and sanitary conditions and account for 40 per cent of child deaths in the poor regions. *Brazil - UNIJUI.*

According to studies carried out in Peru, in 1972 51 per cent of children under 6 years showed some degree of malnutrition. Wiith regional differences: 62 per cent in the jungle; 50 per cent in the mountains; and 39 per cent on the coast. Although we have no general figures, partial studies show a deterioration of the situation during 1978 to 1984. *Peru, Lima - CIDEPSA.*

In Colombia over 100 children die from hunger everyday. 77 per cent of the adult population has a deficit in consumption of

caloric proteins, vitamins and minterals. 66 per cent of children show some degree of malnutrition.
Malnutrition is a primary or associated cause of 41 per cent of all deaths of children under 5 years. Around 57,0000 children under 5 die each year. *Colombia, Bogota - CINEP/NUTRIR.*

In the shantytown of La Victoria in Santiago, malnutrition percentages were calculated for the child population. The rate was 26 per cent for children between 2 and 7 years. This percentage increases progressively with age. Thus we find malnutrition figures of over 36 per cent for children between 6 and 7 years. *Chile, Santiago - La Victoria/QUERQUM.*

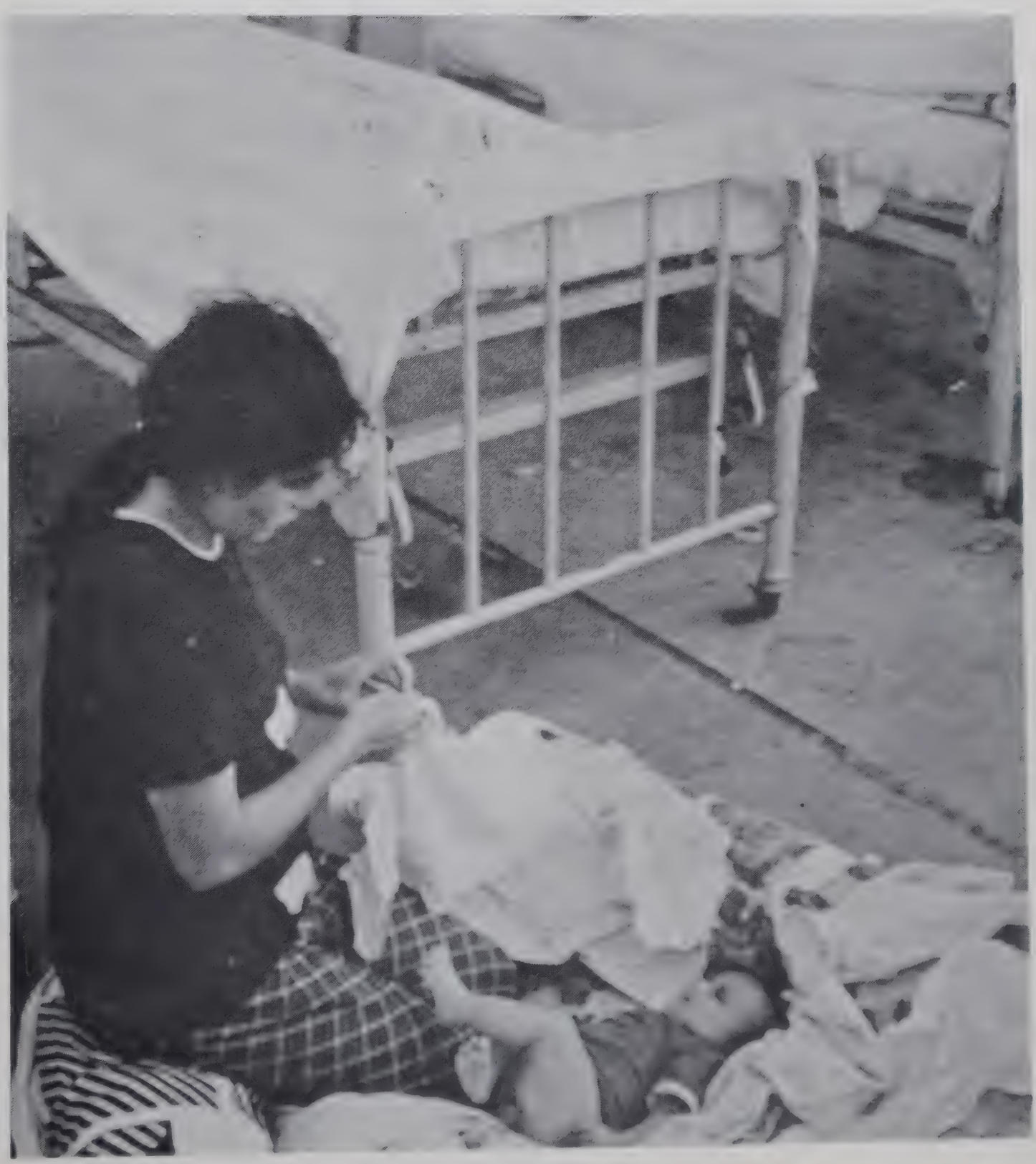
The health systems

Unfortunately, state action tackles the effects and not the causes of people's health problems. Emphasis is placed on curative actions which are not sufficient to respond to the problem and which don't take into account the popular practices and traditions which people use to care for their health. This curative priority translates into a distribution of resources concetrated in urban areas which promote highly sophisticated technological development and often, the transfer of health actions to the private sector.

Promotional and preventive action - present in vaccination campaigns for example - occupies a secondary and sporadic place and for the most part never reaches the majority of the population. Neither approach is attacking the problem at its roots.

The Ministry's current health policy is framed within a curative approach which follows the model of developed countries. It places most resources in urban hospitals with more than 70 per cent of these being allocated to the country's capital. Them emphasis is on specialization. Lima, which has 31 per cent of the population, has an average of 512 inhabitants per doctor while the rest of the country has a ratio of 3,367 inhabitants per doctor. *Peru, Lima - CIDEPSA.*

The elitist health system in Brazil is characterized by: a concentration of resources in the big cities, lack of coordination of policies, multiple health care systems, inequality of social and geographic access and emphasis on hospital care. The overall approach to health emphasizes individual and curative actions. There is an excessive use of sophisticated technology and technocratic management.
Resources are not concentrated in key areas according to need. 84 per cent of resources



are destined to medical-hospital care, with barely 3 per cent to basic health care and only 2 per cent to control of contagious diseases. *Brazil - UNIJUI.*

In the years prior to 1973, several national health programs (some with 100 per cent coverage) were carried out: child clinics, tuberculosis campaign, inmunizations, etc. During this period Chile had an accelerated growth in social expenditure, achieving a basic level health for the population. The Military Coup in 1973 ended this. From a State that considered health a right and aim in itself, health became a means, not unlike a commodity in the market, with access being determined by the law of supply and demand. In this system there is no room for the expressions of the organized community

An important part of the activities carried out by the State are being transferred to the private sector. The State takes on only those activities that the private sector cannot or does not wish to undertake. Thus, everyday there is an increase in the number of responsabilities that the private sector believes part of its legitimate field of action. *Chile, Santiago - VICARIA ORIENTE.*

The Health and Social Security system offers poor service. When the peasants of Veracruz are ill they must go to private physicians who charge between $4 and $25. This doesn't include the price of medicines, generally over $10. For this reason, peasants only see a doctor in very critical situations. *Mexico, Veracruz.*

In Uruguay, there are two health systems: public and private. In theory these cover 80 per cent of the population. But this multi-institutional structure is neither coordinated nor decentralized to the regions. One can observe a deterioration of the system, bad conditions, shortage of financial support and an unequal distribution of human resources. Emphasis is on curative programs, which vary tremendously in quality. Consultations tend to be short. Health technitions are poorly paid. Promotion of health is practically non-existent and prevention—such as vaccination campaigns—is sporadic.*Uruguay, Montevideo.*

The government's response has been imposition of a rigid, authoritarian regime which allows it to control the social order through the implementation of systematic repression at all levels. The core of State health policies have been iminently curative and do not respond to people's real needs, offering them only circumstantial solutions. The major causes of death are still diseases that can be prevented and controlled, diseases connected to difficult economic situations

and insufficient health care. But no preventive actions are taken to respond to these. The problem is not attacked at its roots, and instead actions are restricted to curative solutions, like distribution of rehydration salts or cheap medicines. There are no long-term programs. Instead State policies respond to economic objectives. The intention is to preserve and reproduce the workforce and not to give people a dignified life. Health care programs have been used to relieve social tensions. Implementation of these programs has contributed to the destruction of the forms of expression developed by the popular sectors. These programs attack traditional health practices and collective and community solutions to health problems. *Ecuador - CESAP.*

the problem of hunger, basic sanitation and the creation of health services centered in the community.

The moment for asking why?

This irrational and disorganized approach to health programs and actions must have an explanation. Participants agreed that the rationality of current State actions corresponds to a concept of health based in the market economy. The problem is a structural one affecting the great majority of the continent. Any serious response must be directed towards developing radically alternative policies that start by modifying living conditions and giving priority to

A health system is not simply "a set of practices" outside people's lives and communities. People have always developed ways of responding to their health problems, practices based in their ecological, ideological and cultural framework. This is one of the main reasons for the rejection of our work by the community, both in its curative and educational aspects.

Western medicine individualizes the patient and the disease. The disease is considered to be organic, caused by the ill-func-

tioning of some part of the body, and thus can be systematized according to symptoms. Many mental diseases are also considered organic. In this sense there is an enormous discrepancy with traditional medicine. In the latter, the cause is more important than the classification of the disease and the patient more important than the illness. Treatment is focused on eliminating the cause.

A patient with diarrhea due to "fright" does not find any help in a doctor that can treat his or her diarrhea but cannot cure the fright. When the doctor denigrates or denies the existence of the disease, it is very likely that the patient (and his or her relatives) never come back, even in those cases where a doctor could solve their problem. Thus, many times it is we who create gaps between the community and health professionals and then interpret these as the community not wanting "medical aid." Isn't it true? *Peru, Cuzco - CMA.*

The disorganization of national health services indicates that it is not possible to visualize health a a right as long as the concept of health as a commodity prevails. *Uruguay.*

The model of social and economic development adopted by Brazil in the last decades is characterized by an excessive and harmful concentration of wealth which has not had a corresponding impact on the quality of life and health of the majority of the people. *Brazil - UNIJUI.*

The current Minister of Health has a progressive approach to health and is very critical of the present situtation. He intends to put the organized community at the center of health action, to decentralize decision-making and management and thus transform the Ministry into more of a coordinating body, to use technology according to the country's resources and to emphasize primary health care. The implementation of this policy has shown its limitations. Profound changes in the health situation do not depend primarily on the health sector. Democratizing health implies a democratization of the society as whole.

There is resistance by professionals to modifying their concepts and practice. At the same time the politically organized sectors and trade unions give little importance to struggles for health improvements and thus tend not to pressure for the implementation of what has been planned. *Peru, Lima - CIDEPSA.*

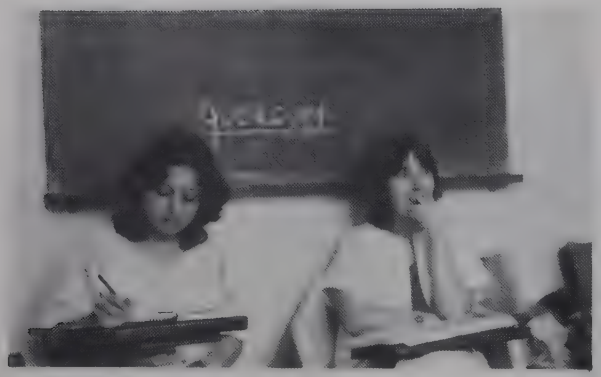
As a result of our years of working in the community of Catacaos, we have corroborated the following hypothesis: health standards rise automatically when the standard of living improves, even without any health education. *Peru, Piura - CIPCA.*


SANATORIO PROLETARIO
DEL
CAMPESINO Y EL OBRERO
D R.

2. THE PERSPECTIVES AND OBJECTIVES GUIDING NON-GOVERNMENTAL PROGRAMS

In the following pages, participating groups share the orientations and objectives of their health programs. During the workshop our discussion focused on several questions: what view of health guides the program? to what extent are they able to incorporate this view into their current practice? what are their long term goals? what problems and obstacles are they encountering? how are they solving problems? In the following chapters different responses to these queries are presented, although we know that we still have only partial answers. Experience differs significantly from country to country. Written material on the theme is prelimary. The debate is only beginning to take place on a national and now on a regional level.

The programs are being carried out by non-governmental organizations and urban and peasant popular organizations in Puno, Ecuador, in Veracruz, Mexico, in marginal quarters in Lima, in Bogotá, Montevideo, Buenos Aires, Santiago and Concepción. Programs are attempting to solve health problems in the communities with which they work, at the same time as exploring and promoting collaboration with other groups and institutions that will allow them to raise a common voice for a different approach to health. This double vocation and militancy is crucial to understanding their programs and overall purpose.

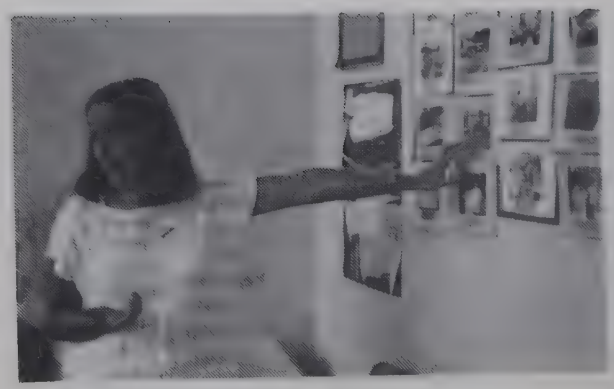


Holistic health

The concept is not new, especially after the intense debate around primary health care that has been taking place since 1978. It is not strange then that this holistical approach to health and health care is present and has developed multiple expressions in Latin America's non-governmental programs. It is a dramatically different approach than the view of health as synonymous only with lack of disease, which—even though rejected by many—still dominates official health practices throughout the continent. *Health does not simply mean the absence of pain and disease. Traditional curative medicine practices in our countries' health systems teach us to identify health with hospital infrastructure, doctors, nurses and medicines.* Quito, Ecuador - CEPAM

The "health-disease" dicotomy has transcended the hospital and health service walls and now forms part of each person's vision of what "health" is. Health is understood "lack of disease". The popular sectors have not escaped this indoctrination. Thus in the community of Catacaos (Pirua, Peru) *peasants immediately bring forth the need to have the presence of formal health services.* They say, *"we are not doing well as far as health is concerned because here we don't have any first-aid stations, polyclinics or doctors. If someone becomes ill, we don't know where to go. We have to travel long distances"*.

Given this strong identification with illness, programs have had prioritize creating conditions that will enable people to understand health from an alternative perspective. As the Comisión de Peñarol (Montevideo, Uruguay) pointed out, *we want people to become aware of the fact that health is not only a problem of medical attention.* The concept of health that they promote is a synonym for living conditions in all its different dimensions: housing, work, land, employment, education, fair salaries, food, basic sewage system, etc. The program's



objectives are defined according to this option.

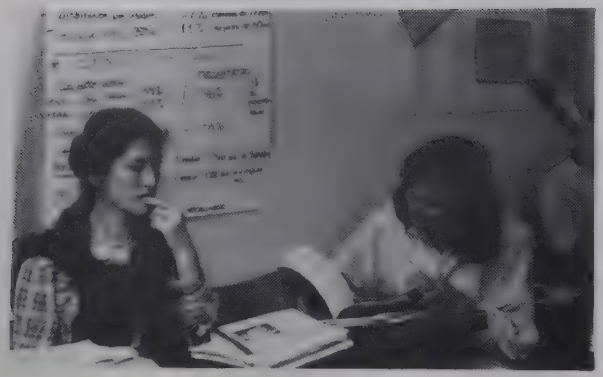
Once you recognize that most diseases are a clear expression of living conditions, it becomes obvious that health improvement is more a social than a medical problem. Thus it is necessary to increase preventive actions at a socio-economic, political and cultural level so that they have an impace on living conditions. Bogota, Colombia - CINEP.

The different programs invoke a holistic concept of health, as a process of interaction and transformation of individuals and of the society. UNIJUI's health program sees *health as a continuous action of the human being facing the physical, mental, and social universe in which he/she lives expressed as much through the understanding and the struggle against the conflicts imposed by the universe as in those moments when s/he manages to solve these problems and thus eliminate their contradictions*. In the same way, the experience of Instituto del Hombre in Montevideo suggests that it is necessary *to recognize human beings have been deprived of their own being, being forced to live in a permanent state of imbalance and deterioration. A healthy individual is a potential and health sciences are sciences for the development of human potentials*.

This vision of health, which is the framework in which many NGO health programs operate, *incorporates the view that health also means society' s capacity to respond to people' s needs, through a policy that is socially fair and that will generate adequate measures for promotion, protection, preservation and recovery of health*. Brazil - UNIJUI.

People's health problems must be considered as a whole, *from health promotion and prevention of disease to the treatment of diseases according to levels of complexity and the recovery of lost facilities*. Lima, Peru - CIDEPSA.

The identification of different actions according to levels of complexity (in health as well as

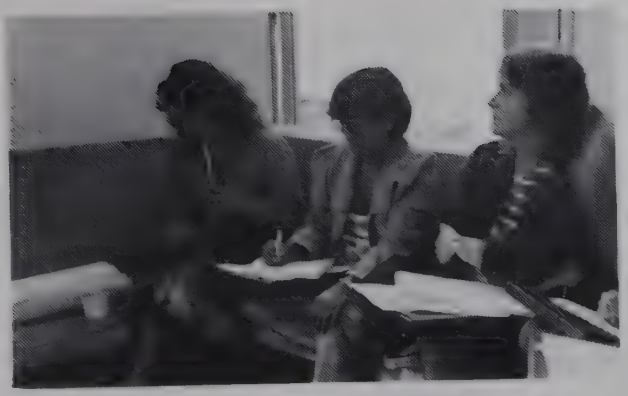


in social and political dimensions) is present when groups recognize the need to coordinate with formal health systems and to promote popular organizations. One of the clearest examples can be seen in CIDEPSA's project prospective, when they express that *we want to construct a popular health network which takes a holistic approach in a framework of territorial responsibility. The community, organized in neighbourhood committees, must take responsibility for health issues as a central aspect of its daily work and organize autonomously to meet its health needs, linking this type of organization to the formal health system at a municipal level.*

Thus groups strive to express this broader understanding of health in strategies of action which will change people's health conditions and develop community organization and participation as an integral part of existing health services. Perhaps this is the greatest challenge—to advance a theory and practice of health as an integral part of the struggle to change the community and to improve individual and collective living conditions.

Criticism of present health systems

We have already noted that non-governmental programs oppose a narrow and out-dated concept of health. It should be pointed out that often this involves groups criticizing official health policies, something which is particularly difficult in non-democratic contexts or in countries where there is no policy favouring the development of primary health care. This is the case of course for Chile - VICARIA ORIENTE QUERCUM and INPRODE. These programs recognize the relationship between health and the social and political order and thus work to formulate strategies aimed at mending the forms of social organization and health care destroyed and/or denied by the military regime.



The experience of CLAEH in Montrevideo, Uruguay is similar. They direct their work *to improving the conditions of health, changing the present system, promoting preventive actions and the self-managed and organized participation of people in solving their own health problems, supporting the efforts of groups working in primary health care and coordinating with other group involved in formulating alternative policies to guarantee equal rights to health.*

In these and other examples it is rare to find criticisms that are not accompanied by alternative proposals, perhaps not fully developed but clearly arising out of the different experiences. Each program includes a search for new models or ways of reorganizing existing health systems. There are even examples where government policy is being developed according to the framework of primary health care, in Peru for example. The challenges for NGO program are different in these contexts. In Peru groups face the obstacles created by the society itself which often oppose attempts at transformation. Thus we see health professionals, traditional social and political organizations and orthodox parties blocking change in the field of health.

Proposals for change

What are the main components emerging from the practice of different groups and with the active involvement of the community? It is out of these experiences that progressive alternative health models will be developed.

To develop popular organizations that undertake responsability for responding to problems at the local level. This option is expressed in all the experiences presented:

The objective of our health work is to support and promote people's organization which, by means of an educational process, will assume the key role in the area of health. This will take the form of concrete actions for development, prevention and recovery. Santiago, Chile - VICARIA ORIENTE.

CESAP's *line of work is to support popular education and organization, and is based on solidarity actions in the struggle for health.* Ecuador - CESAP.

The purpose of the Health Program of the community of Catacoas is to create the basis for an indigenous community organization capable of responding to health problems in the community. Piura, Peru - CIPCA.

To respond to health needs by providing curative assistance and using available human and technical resources which are appropriate for each local reality. Thus, the first action of CIDEPSA's (Lima, Peru) program was participating in the vaccination of every child under 5. INPRODE (Concepcion, Chile) developed a campaign against scabies which helped to legitimate the group's work. In the community of Tuxtlas (Veracruz, Mexico) curative services were organized through local promoters who used herbs and systematically recorded diseases.

To do ongoing education, carrying out training activities with organized groups as well as doing conscientization with participants in the different programs. It is within this perspective that EPES (Santiago, Chile) *trains health monitors who through their activities contribute to the achievement of health as a right and community responsibility.*

Conscientization is also a priority in some programs, for example in Tuxtlas (Veracruz, Mexico) where they believe that *educational work is the main axis for people to discover how the root of their health problems are located in the social structure and the need for its*

transformation..

Health educational practice is considered a point of synthesis between the curative and the organic, between the micro and the macro. This educational practice forms a bridge between the knowledge of Western medicine and traditional practices. It is a permanent educational practice based on the principles of popular education which promote the creation of a "critical" understanding of reality and actions for transformation.

To challenge and debate the role of professionals in popular health experiences. This is key given the history and authoritarian image of health professionals. The work presented by Instituto del Hombre explored this issue. *We have to reflect on and question ourselves about the way in which we approach reality. We must develop an approach which takes into account the reality of the popular sectors as well as our own reality, conditioning and limitations. Then from that base we can search—in close collaboration with the popular sectors—for the common illness that we suffer and possible projects of change today.*

The Instituto starts by recognizing "our own dissociation" and tries to establish a relationship based on "mutual co-discovery". Other teams are also working to create democratic, horizontal and non-authoritarian relationships, through curative and educational programs and by promoting and developing organizations. They acknowledge how this practice produces a process of professional "re-education". Definitively, and from different points of view, they try to change the hierarchical and authoritarian relationships that are integral to medical practice, attempting alternatives that combine a technical contribution with a process of popular participation.

To develop opportunities for networking among non governmental organizations and, sometimes, with the State sector. There are programs whose main focus is networking

and who are playing a facilitating role with other groups. CESAP, for example, which is made up of health teams working in different places in Ecuador who are linked to local popular organizations.

Centro de Medicina Andina works primarily in coordinating and promoting links between groups in Peru. They bring together professionals from the Andean South—be it private projects or pastoral and/or State health groups—with the purpose of developing reflection and practice on the subject of traditional medicine in the context of primary care.

Many other programs are also involved in some kind of networking. INPRODE (Concepcion, Chile) are meeting with other programs in the area to reflect on and systemtize the experience of NGO efforts. In CLAEH (Montevideo, Uruguay) they want to initiate more exchange and communication with other groups concerned about primary health care. In CIDEPSA (Lima, Peru) they are making efforts to coordinate with other groups in the region. VICARIA ORIENTE, QUERCUM and CEAAL have formed a collective decidicated to promoting community health.

In this way the partial effect and impact of small and often isolated programs can be analysed, acknowledged and perhaps extendeded to other experiences. Coordination between groups is a first step in beginning to build a bridge between small micro experiences and to developing alternative systems on a more global level.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PERO VIENE EXPRESION
LENTO VIENE EL FUTURO LENTO
EL CANT TIENE SENTIDO Y RAZON
NERUDA
VIVE EN EL CO.
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PUEBLO.
POPULAR
LEVANTATE Y MIRATE LAS MANOS
HERMANO.
VICTOR
JARA
LAUER DE
PINTURA
POPULAR
EN ESTA PROXIMA CANCION
QUIERO QUE TODOS ME ACOM
PAÑEN POR FAVOR
AQUELLOS DE LOS ASIEN.
TOS MAS BARATOS,
APLAUDAN.
EL RESTO DE UDS
PUEDE HACER SO-
NAR SUS JOYAS.
JOHN LENNON

3. FROM PRACTICE TO PRACTICE

Here we present a summary of the different groups' program experiences, which they presented in the workshops. The emphasis is on practice.

1. Brazil: From university practice to community health

FIDENE (Foundation for Integration, Development and Education of the Northeast State) works in the municipality of Ijui, State of Rio Grande do Sul. From an ethnic point of view Ijui has a heterogeneous population. The major activity is agriculture, which has evolved from small properties to a modern export-oriented industry. This situation has forced poor peasants to migrate to the outskirts of the cities.

The experience involves two groups. On the one hand, the students of Nursing, Obstetrics and Nutrition at the University of Ijui, and on the other, the rural and urban-peripheral sectors of the county of Ijui. Municipalities, state secretariats, urban and rural trade unions, neighborhood associations, churches, schools, cooperatives and foreign foundations also participate.

In 1980, the FIDENE and the University of Ijui began discussing the possibility of a health project aimed at creating nursing, obstetrics and nutrition courses for community organizations. The university had wanted to act as an agent for change, and therefore favoured integrating training and extension through an exchange with institutions and the community.

The University organized seminars and meetings which culminated in the creation of the Ijui Municipal Health Inter-institutional Commission to supervise collaborative actions. This practice gave rise to a system of coordination between different institutions which are active in the life of the community: the local hospital, municipal secretariats, outpatient clinics, cooperatives.

The health projects that operate in the municipalities as integrated action centers are counselled by the University and include health agents, technicians and the community. These centers are places where the community can participate in the management of health activities at a local level. They also belong to an inter-institutional governmental program.

Integration with community groups allows for educational processes that promote the gradual development of a critical conscience, which seeks to understand reality, not only from a health perspective, but also in terms of the political, social and economic aspects of existing health conditions. This requires promoting participation and responsibility on the part of both the technicians and the community. They discuss expectations and needs related to health. The methodology which has emerged begins with determining problems, and moves through to prioritizing alternative solutions and implementing actions.

At a local level, support is given to community health workers. These are named by the community according to the criteria established jointly by the community and the technical team. Training is organized based on the community's needs, and is determined by a combination of formal and in-

formal diagnosis.

In regard to the training of professionals at the University, one must consider that these professionals have traditionally had tremendous power within the health arena, controlling problems and making decisions within insitutions, even in relation to a person's own body. Because of this, a new more general training has been proposed in which technicians would acquire a more holistic perspective. Professionals would also be trained to care for, protect and restore health, eliminating the dichotomy between the preventive and the curative.

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BRAZIL

2. Colombia: basic foodstuffs and price control

Fifteen percent of the country's urban population lives in the city of Bogota, where the country's political-administrative apparatus is concentrated. Bogota has historically encouraged migration, especially from the countryside. The city's industrial boom also resulted in increased urbanization and, along with this, the price of land skyrocketted. In the last 100 years, Bogota's population has increased 80 times. Migrants who do not get jobs occupy plots of land illicitly. Women are involved in production, especially in the service area.

CINEP works with the marginal housing sectors of Bogota and also with CIPROC, the Community Promotion and Research Center. The starting point is in recognizing that health is a need of the popular sectors, but also that it is an instrument of control.
When you recognize that diseases are a manifestation of living conditions, it becomes necessary to develop preventative actions at the cultural political and socio-economic level, which will have an impact on these conditions. In 1984, we undertook a study of food intake of the poor sectors in Bogota. The objective was to explore in-depth the community's standard of living, basic food stuffs and nutritional level.

We prepare a monthly Index of Food Prices based on a CINEP survey. Every two months we publish a cost of living bulletin for use by community and other groups as a basis for trade union negotiations.

The first Health Group Workshop was held with 72 participating teams. The purpose was to reflect on our different programs and to create a coordination and support network.

The health and popular education orientation has developed around a structural analysis in which health and illness are seen in their broader context. The debate on State action, the search for tools for participatory and organizational work and the definition of an educational process are also central discussions in the program.

CINEP
Carera 5 No. 33A08
(Apto. Aéreo 26916)
Bogota, COLOMBIA

3. Colombia: malnutrition and community participation

The program takes place in neighbourhoods in the northeast of Bogota. These are the zones of rock and sand quarries. The population belongs to the lower socio-economic level, coming originally from the countryside. The houses are built with precarious materials on eroded land. There are no water, sewage, or garbage collection systems. The high population density has contaminated the few natural sources of water.

NUTRIR's objectives are to prevent child malnutrition and to promote children's physical and social development.

The principle that guides our work is health as a right for everyone. This implies:

* promoting a deeper "understanding" of health in order to prevent (and not only to cure);
* "organizing" in order to pressure the State;
* "disseminating" knowledge in order to raise the level of people's awareness of health and its social implications.

The program is divided into 6 sub-programs: nutrition, health, environmental health and urban improvement, community and juvenile promotion, income creation, and activities to support the development neighbourhoods.

A community health pilot program was started in 1985. In 1987 it will be extended to seven neighbourhoods. Currently we are working with 17 health promoters, each of whom receive training and economic compensation. The program includes:

* community participation in diagnosis of health and nutrition problems;
* training of teams to promote and extend the program;
* preventive activities through education;
* identification of "high risk" families in terms of nutritional problems in order to better focus protection and recuperative actions.

NUTRIR Foundation
Carrera 4 No. 66.86
(Apto. Aéreo 90-328
Bogota D.E., COLOMBIA

4. Chile: organization and milk

The "población" of La Victoria, located in the southern section of Santiago, was established through a land seizure in 1957. Thus from the beginning there has been a high level of organization within the community, although this deteriorated significantly after the 1973 military coup. Since 1978 people in La Victoria have begun to re-organize around solidarity activities.

In La Victoria we work primarily with the children, Christian organizations and health groups. Health professionals help in the diagnosis of different problems.

Our health practice is organized with an educational and advocacy focus. Our block milk program, which consists of delivering milk to children in the community who are suffering from malnutrition, was developed within this framework.

To begin with, people from the community who had been trained in health made a diagnosis of the nutritional levels of the infant population. This involved periodic check-ups of weight and size. The unorganized sector of the community, including mothers of children suffering from malnutrition, participated in the preparation and distribution of the milk.

The program involves:

* selecting a priority group among children between 2 and 7;
* training healths monitor in nutritional evaluation;
* educating mothers in the preparation of milk;
* organizing within the community, with one person per block being responsible for the program;
* community education about the problem and program so as to achieve a greater level of commitment.

Querqum
Malaquias Concha 0185
Santiago, Chile

5. Chile: health as solidarity action

The health team of Vicaría Oriente works in urban poor shantytown communities in Santiago. Until 1973, Chile had an impressive level of development in health. The Military Coup interrupted the process and introduced an economic model which heightened social differences and dramatically increased the unemployment level. At present, unemployment varies between 40 and 70 percent for heads of families in the marginal neighbourhoods.

In Chile, heath is no longer considered a right in and of itself. Instead it has become a commodity commercialized in the market according to the laws of supply and demand. Public expenditure has been reduced dramatically and many important activities transferred to the private sectors. Along with this, new legislations have been introduced to reduce free medical care.

One assumption underlying all our work is that it is impossible to separate the problems that arise day-to-day from the need to survive and from those related to the creation of critical awareness. For this reason, health activities are part of a whole set of social solidarity programs that support people's organizations within the community: soup kitchens, housing committees, income generating workshops, women's groups, collective purchases and others. Health groups and iniatives develop out of these groupings and programs.

The groups seek to learn ways to face, in an organized manner, the health problems arising from the deterioration of their standard of living. They also demand services from State authorities.

The program has a strong popular education component. Training of health groups starts with an analysis of the community, which is always organized as a participatory activity out of which the group decides on its future tasks. Techniques such as discussion groups, drama, games and body expression are used to facilitate participation, dialogue and to ground discussions in the concrete reality. As well videos, pamphlets, slides and collages are used and/or created.

These groups have matured tremendously in the past few years. Recently they have begun to create sectorial and district coordination networks. This has permitted the organization of a broader range of programs which can offer health care for one or more

communities. It has also made it possible to exchange experiences and resources.

At present in the south-eastern zone of Santiago, 50 health groups are operating, 20 of these are connected to the Vicaría.

Vicaría Oriente
Los Alerces 2900
Santiago, CHILE

6. Chile: Participatory training for health monitors

Popular Education for Health (EPES) works in the urban-marginal areas of Santiago and Concepción where living conditions are continuing to deteriorate as a result of hunger and unemployment. At the same time groups and organizations are organizing to demand their right to a worthy life and for full social and political participation.

We work with community organizations such as soup kitchens, kindergarden parents and guardians, mothers of children suffering from malnutrition and others. The objective is to improve their health by means of their active involvement.

By 1982 we had carried out the following activities:

* training of monitors: using participatory methodology that builds on participants previous knowledge and promotes group autonomy and the use of community resources. Within this perspective we use a wide range of specific techniques such as: small groups, theater, puppets and other other entertaining activities, relaxation, linking personal knowledge with collective analysis. We also create educational materials.

* health workshops: with the intention of both providing a service and stimulating the community to become trained to respond to basic health problems.

* methodology workshops: provide a space to share experiences with other groups that carry out educational work in popular sectors.

* counselling of existing groups: a support to their further development and growth. This involves providing information, incorporating new educational techniques, supporting group leadership and

increasing the capactiy to coordinate with other groups working at the community level.

EPES
Casilla 15167
Santiago, CHILE

7. Chile: community health campaign monitors

We work in Tomé, thirty kilometers from Concepción. Tomé had a highly developed textile industry which has declined to the point that only one of three major companies is operating. At its peak the industry employed around 16,000. Today, with an economically active population of 18,000, the unemployment rate stands at 31.1 percent.

IMPRODE also works in in the nearby city of Medio Camino. Medio Camino has an urban population with characteristics similar to Tomé.

In both communities we work with people involved in health programs, including some government bodies and alternative regional health groups.

There has been a small health group in Medio Camino since 1985. It is composed of 18 people, and is supported by a nurse and a doctor. It was formed by a youth group that used to run a hot meal drop-in for children.

The group's purpose is to serve the community. It's activities include training health monitors, speaking at local schools, adult and child primary health care, training monitors in hygiene and in the technical and socio-political aspects of health, and carrying out a prevention-educational program for kindergarden children and their families.

We started work in Tomé four months ago. Since then we've developed training courses for health monitors and now have 25 participants coming from different sectors of the city. The objective is to learn and develop a critical attitude regarding basic health problems so as to better equip communities to deal with problems collectively.

We hope the work in Tomé will fulfill several goals:

* First, training groups to organize and in first-aid and nursing techniques.
* Second, setting up an outpatient clinic which will also develop educational programs with the community.
* Third, providing a primary medical and dental service a few hours a week.
* Most important is to promote the group's critical capacity to confront problems at their root.

We also hope to be able to generate independent resources so as to give the group more autonomy.

In both communities programs combine an educational process (development and organization) with preventative services. Throughout, priority is given to a participatory, horizontal and dialogic methodology.

Programs are also involved in a regional effort to link alternative health institutions and programs. Groups meet to systematize and evaluate experiences.

IMPRODE
Tucapel 339
Concepción, CHILE

8. Ecuador: health teams fight for people's rights

Ecuador is a country that is undergoing a serious crisis caused by difficult economic, political and social conditions. As a result there is a progressive pauperization of the people. Living and health conditions are decreasing to a critical point.

CESAP (the Popular Health Team Coordinator) operates as teams of professionals working with grassroots and peasant organizations in the Coastal, Andean and Eastern Lowlands regions. The teams work with peasant organizations, community health workers and formal health workers.

CESAP, which began work in 1985, has its orgin in the state programs that sought to provide health care for the rural sector. Doctors, professionals and grassroots organizations participated in these programs.

CESAP's objectives are to work with grassroots organizations to:

* generate alternative for health care and health promotion;
* develop an active critique of official health policies;
* promote an understanding and dissemination of traditional knowledge;
* support urban and rural grassroots organizations in their demands for the right to health.

CESAP organizes periodic meetings where teams can share their experiences. These are moments of discussion, learning and exchange. We also issue a bulletin that highlights the experiences of each group, reports on decisions taken at meetings and provides information on new resources. Both activities contribute to breaking the silence, resignation and passive attitudes that exist in relation to health.

CESAP sees mass health education as a priority. Thus, we emphasize popular education, critical reflection and recovery of popular medical knowledge rather than medical and technical management. CESAP aims to insert itself in the everyday needs and struggles of the people in order to promote critical consciousness and social change.

After three years of work, CESAP has managed to create spaces for discussion of health issues at the local level. It has under-

taken studies and systematic reflection with the different health teams.

CESAP
Casilla 216
Cuenca - ECUADOR

9. Mexico: putting health in the people's hands

Mujeres Para el Dialogo works with the Tuxtla peasant communities in the southern state of Veracruz. Veracruz has seven million inhabitants and is located in southeastern Mexico. It has a tropic climate that favours land fertility and a sub-soil rich in oil and sulphur. Its major economic activities are cattle-raising, sugar cane and tobacco—all for export. This natural wealth contrasts with the poverty of peasants, most of whom don't have any lands of their own and must live on minimal salaries.

At present we work in 26 villages, with 47 promoters from the communities. The program links two zones, one which includes 22 villages, and the other, four. The two groups meet periodically to evaluate and plan.

At the local level, the Popular Health Committees are the mechanisms through which people are beginning to struggle for their right to health. People are elected to these committees by the community and the promoters.

The overall goal of our work is for people to take control of health into their own hands. This means becoming aware of the social causes of disease and developing the capacity to organize themselves to face health problems. The methodology is based on the principle that people must be the subject and not the object of health actions. We work with base-Christian communities promoting different health-related activities. We work to form community organizations that will participate in work at a local, zonal and national level.

To date our work has consisted of:

* Conscientization through local meetings: popular theater dynamics are used; promoters exchange experience; an exhibition of the region's plants is organized, and a reflection based on the Christian message is made of different experiences;

* Participatory research on community health: after dissemination of medicinal plants, research was carried out in 1984 in ten villages. The results were the motivating force behind the initiation of the current work. In 1986 research was carried out to detect the most frequent diseases and thus plan the work to 1987.

  In the area of medicinal plants, research has been carried out with the objective of

detecting, recovering and disseminating the existence and the use of medicinal plants in the region. For this purpose a dry herbarium was built, made with plants brought by each promotor. The information about the different plants was systematized. In the end we made a recipe book with 50 plants.

* Training is carried out through workshops, coordinated by a team of promotors who rotate coordination of the organization and program planning.

To reinforce the view that health problems are causes by the prevailing conditions of injustice, training starts by classifying diseases according to their social causes. For example, in 1985 we studied diseases caused by the lack of running water and sanitary services.

* Preventive health takes place through community organization. Popular promotors have been trained in homeopathic medicine. They offer health care according to local needs. It is a free service and cooperation is asked only to keep up the first-aid kit.

Mujeres para el Dialogo
Apartado Postal 19493
Mixcoac código 03910
Mexico, D.F.

10. Peru: building on the strength of existing community organization

We are involved in a health project with the Peasant Community Organization of San Juan de Catacaos, in the north of Peru. The communities of San Juan de Catacaos have an important cultural and community cohesion. It covers 30,000 hectares of productive land, which are cultivated with different crops. Land ownership takes several forms: worker communal cooperatives, communal production units and small land owners. It has a population of 100,000. San Juan de Catacoas has a high level of organization and has continually defended its interests. Improvement of services and the promotion of a better organized awareness in areas such as health must be viewed within the perspective of a strong base of community organization.

CIPCA was created during the process of Agrarian Reform carried out in 1972 by the government of Velasco Alvarado. It was founded with the objective of training peasants who received lands. The community health program started in 1979 and was developed jointly by the CIPCA team and the community. The overall objective is to meet the needs of the people who are outside the official health system in a way that takes advantage of and builds on the existing high-level of organization. To do this we aim to leave in place a community organization that has the capacity to respond to health problems in the community. To achieve this it is important that the program be inserted in the communal structure and not exist as a separate parallel organizations. This means dealing with the cultural problem of health in countryside where there is a contradictory cross between services provided by curiosos, healers, prayer sayers, herbalists and witches and those provided by the formal health care centers.

At the beginning the community thought that the program should focus on providing medical care. They also thought it should include the whole community and not select only some villages. These proposals initiated a long period of discussion and exchange through which the community started to better understand what a health and popular education program could be. At the same time, the program understood what its role should be, from the communities' point of view, especially regarding its range. Finally, it was concluded that the program would be oriented more to educa-

tion than to assistance, but that a first-aid kit would be installed in the community's central office, and that a nurse and doctor would work there twice a week.

Activities have been carried out with the support of the health promotors, the health committee, and community authorities and organizations. These treat promotion and education as part of a process of learning by doing. The main lines of work have involved:

* *Medical assessment of school children*: this motivated wide participation because of the alarming malnutrition rates. Teachers and parents sought to improve the delivery of food coming from the Health Ministry.

* *Participatory research*: this consisted of a health diagnosis carried out by peasants. They prepared and did interviews, tabulated data and then issued a booklet based on the information they had gathered.

* *Campaigns*: these were divided into four stages—census, promotion, execution, and evaluation. The campaign to control malaria is worth mentioning as it succeeded in mobilizing the community and responsible organizations. Vaccination campaigns have also been successfully carried out.

Each one of these activities is carried out with communal organizations and involves the training of community health promoters. The idea is to extend the program to the whole community. Thus, a structure of promoters and midwives has been set up to cover all the villages. The promoter is responsible for most of the programs as she or he is the link between the program and community and thus is the key element to influence the community in making the project their own.

Courses are not considered an important part of training promoters. Instead the focus is on action, learning by doing. Promoters from different villages meet together once a month in teams, each of which elects one person as coordinator. Promoters are volunteers; they do not receive any salary. They receive small allowances when attending meetings, seminars or courses. One of the coordinators, along with a member of the central leadership, take on the task of expediating communinication between these two groups.

There was one guarantee of success in this experience: the fact that the program relied on the communal organizational structure

already in place. San Juan de Catacoas has 408 years of history, marked by an on-going struggle for communal autonomy and land. It possesses a great cultural cohesion based on its traditions, beliefs, ways of reflecting on and interpreting the world, and of acting on it. It also has a strong union organization. The success of health programs or of any popular education program depends on the soundness of the popular organization that supports it: this is the case of San Juan de Catacoas.

CIPCA
Apartado 303
Piura, PERU

II. Peru: from suburbs to districts

This experience started in the popular neighbourhoods in Lima, in the district of Carabayllo which is located 23 kilometers north of central Lima. Carabayllo has a population of 37,000. It is a community without running water or sewage, although work has now started for its installation. Forty percent of the population is between five and 24 years. Community organization is not strong, but there is a base level organizations of what could be called medium-level.

CIDEPSA (Research and Development Center for Health Programs)'s work is directed to the inhabitants of the Carabayllo ditrict: neighbourhood committees (each of whom elects health delegates), the Community Health Council (formed by the delegates). the Municipal Health Council, health professionals (teachers, sociologists, doctors), the Raul Porras Settlers Association, the Church (which provide a nurse), and the Glass of Milk delegates (independent community committees linked to a national milk distribution program). We also cooperate with other NGOs working in the dist .ct, mostly in exchanging information.

This program has been operating for 18 months. At the district level, a health plan has been coordinated with the Muniecipality with the purpose of carrying out campaigns destined to improve community health. At the community level, we have worked with the Raul Porras Barrenechea neighbourhood.

The objective is to build a popular health network that links each family through their neighbourhood committee to the municipal and then, with the state structure. Prevention and curing of diseases will be handled by different points in the network, depending on their degress of complexity. The network will be activated through health delegates, who will be responsible for specific families.

Actions carried out within the neighbourhood:

* Contacts with the community's central governing committee to reach initial agreement on carrying out the project;
* Vaccination of all children under five years (an action which legitimized the community's health delegates);
* Census of inhabitants, their educational experience and living conditions. The

information was tabulated and analyzed with health delegates;

* Setting up a communial firt-aid kit and pharmacy;
* Design of the personal health card jointly with delegates in order to maintain better records and facilitate carrying out health check-ups.

Most of the health delegates are women. They have been trained to carry out vaccination campaigns, to monitor vital functions and body measurements, inject medicines, to register patients, use cards and statistical reports and to carry-out follow-up visits in patients homes.

CIDEPSA
Alejandro Tirado 217 - 301
Lima, PERU

12. Peru: traditional medicine in primary health care

CMA was an initiative of professionals and pastoral agents. The Andean Medicine Center works to encourage the use of traditional medicine and to create a health system which is within everyone's reach, both culturally and economically. The work is carried out in the southern Peruvian Andes, in the provinces of Puno, Cuzco and Apurimac, in conjunction with Catholic Church pastural teams, with state health teams from the Ministry of Health and private groups.

Due to the profound difference between western medicine and Andean culture, reasearch and search for the use of Andean medicine demands that professionals be prepared to question the knowledge-base of their expertise and be open to other kinds of medicine. Because of this, CMA places great emphasis on providing professionals with space to reflect on their activities and the values and errors of the Western system of health they have been trained in and to learn about Andean medicine.

As a way of supporting the discussion and exchange the CMA has carried out a range of concrete activities.

* Health diagnosis: is a task carried out by professionals and the community, the latter being the one that points out their true needs, and which includes the services of traditional Andean medicine.

* Evaluation of work with promoters: with

the purpose of identifying the problems and obstacles.

* Gathering and dissemination of medicinal plants: the tasks is not only to gather plans, but also to know the significance of the different plants in communal life. Information is obtained on how different plans are used in treatment.

* Traditional midwives: the idea is to understand peasant midwifery, to value their work and to obtain official recognition, and to involve them in health work. To this end we have been experimenting with new participatory training methods appropriate for women who cannot read or write.

These current tasks, the result of a seven year process, have allowed CMA to accumulate a rich experience and basis for reflection in the area of Andean health. The group does not speak so much of concrete results, but of advances within a process of change. These advances generate new questions as well as new approaches for research and exchange.

Centro de Medicina Andina
Apartado 711
Cusco, PERU

13. Uruguay: questioning professional practice

This experience takes place in the Southern Quarter of Montevideo, which is a marginal neighbourhood in spite of being in the center of the city. The area has a large black population who are currently being threatened with expulsion as a result of municipal modernization projects intent on transforming the area into a residential district.

Research is carried out on health issues in cooperation and participation of neighbourhood organizations. The work began when the health team carried out an initial research project to investigate the community's health conditions. They did a series of door-to-door interviews asking about life in the community. The results were recorded, analayzed and used as the basis for a series of 14 meetings with community residents involved in the Neighbourhood Development Committee. Plans of action were developed and the team began to work with the Committee to act on problems.

Group work carried out during the experience has been important. It has been therapeutic in that it has provided people with an opportunity to leave their confinement, release tensions, meet other people, chat and share. It has been pedagogical in that the meetings, and the experience as a whole, has in a sense been a school in which everyone has learned together and from one another. It has been an experience in which professionals and community residents learn from one another.

The health team continues to analyze and question three dimensions of its practice:

* the tension between promoting social change and professional practice, which often leads to choosing one or the other, depending on existing circumstances;

* the problems of specific fields—such as psychology—whose techniques do not suit the popular sectors;

* the fact that many in the time have been supporters of a political vision and practice that was defeated, was not taken up by the popular sectors. This calls for reflection and serious questioning in terms of the present work.

For each of the above it is important to continually analyze the inter-class practice between residents and professionals and to

draw lessons for improving the work.

Instituto del Hombre
Canelone 1204
Montevideo, URUGUAY

14. Uruguay: starting door to door

The program takes place in the Peñarol Quarter of Montevideo and is coordinated by the Health Committee of the Peñarol Quarter. The main actors are the community residents, the Health Commission, the outpatient clinics, and various community groups.

The Health Committee of the Peñarol Quarter which formed in February 1984 has as its objectives to become acquainted with and anlyze the quarter's health problems and to promote the participation and organization of community residents. The idea is that the community must equip itself to face serious and everyday problems.

Diagonostic activities started with neighbours through meetings in family homes. These confirmed that the most serious problems were the lack of running water, electricity and the presence of garbage dumps. Later, neighbourhood assemblies were organized where the information collected was shared and different actions organized. We started with a day of eradication and cleaning. Then measures were taken to try to obtain electricity, which will be installed soon. Finally neighbours helped in the building of the marginal neighbourhood outpatient clinic and contributed to its ongoing operation.

Comisión de Salud del Barrio Peñarol
Manuel Fortel 1806 - Barrio Peñarol
Montevideo, URUGUAY

15. Uruguay: marginal neighbourhood outpatient clinics

The Latin American Center for Human Economics (CLAEH) works in the outpatient clinics in Montevideo's marginal neighbourhoods. These outpatient clinics are linked to neighbourhood committees, religious insitutions, clubs or cooperatives. In many cases they constitute the only primary health service in the community and thus provide health care to a considerable proportion of the people. Clinics have few technical resources at their disposal and depend on support and contributions from the community. As regards their programs, some only provide assistance; others carry out promotional work together with the community.

The work is directed towards improving the life and health conditions of the people, promoting community participation and coordination between groups working in primary health, and formulating alternative policies to press for health as a right for all.

CLAEH works with marginal neighbourhood outpatient clinics and popular organizations. Within the communities, support is given to the existing outpatient clinics in Montevideo's marginal quarters. These have emerged as non-profit centers as the result of the solidarity efforts of some professionals and religious groups.

The idea is that these centers develop the organizational capacity and orientation to promote Primary Health Care. To this end, a participatory diagnosis of the neighbourhood and its problem was made. This permitted the joint discovery —by technicians and neighbours— of problems and possible solutions. Health educational priorities emerged, users were integrated into concrete tasks of the service, and groups that include technicians and community residents were formed.

One achievement has been better coordination between outpatient clinics. Now clinics work together to define common aims that go beyond the role of only providing assistance. Priority is given to community participation. This demanded a special effort by the health team which had to undergo training in order to learn what life is actually like in the community and what the fundamental concepts of PHC are.

In terms of community organization, we are

working with the Health Committees and Neighbourhood Promoters, showing respect for the existing organizations. The responsibilities of these organizations are related to: the identification of health problems; guidance in naming priorities; formulation of work plans; coordination of the actions of the different health agents or with other local and national institutions; periodic evaluation of work; creation of an organizational structure that satisfies the needs of the community; and integration of the work processes with overal social and sectoral promotion projects.

Training of health promotors, which we define as "training of educators", is essential to the success of the program. As their work is done together with the neighbours on a promotional and preventive basis, it is essential that health promoters seek to know the quarter and its health problems, are acquainted with a range of health issues, and develop skills in planning, evaluation, and group work methodologies.

CLAEH
Zelmar Michelini 1220 T
Montevideo, URUGAY


Diego Rivera 3.


ESCUELA E IDAL

4. COMMUNITY INVOLVEMENT IN HEALTH PROGRAMS: RESPONSES AND CHALLENGES

This chapter includes exerpts from the workshop discussions related to the problem and contradictions that groups face in striving for community involvement and control in health programs. We present this panorama, with its full of commonalities, hopes and contradictions. Active participation and involvement is a priority for each of the programs, although the diversity of contexts in which programs are operating gives rise to many different experiences and results. It's important to keep in mind how often priorities and results are shaped and and influenced by the political conditions that communities and groups face.

The debate

The group felt it was important to try to define what is meant by "involvement" in health programs. We were able to agree on some of the assumptions we shared.

* The relation that exists between health and illness is one indicator of the level of exploitation. In the face of this involvement is a key to change.
* Popular participation is yet another way to break isolation, passivity and silence that many in the popular sectors experience.
* Participation can generate organization and unity that will open the path to a process of change.
* Involvement in health must also signify the power of decision-making.

Our agreement on the above, allowed us to focus more clearly on a central question that each program grapples with at each stage of their work:

How can we promote practice participation that is part of a political and social process rather than simply a struggle for daily survival?

The commitment to this view of "participation" is present in each experience. It is a long-term strategy and for some also an achievement, although at this point only at the local level.

These different facets of participation—as commitment, as strategy, as achievement—can be best understood in the context of the marginalization of important sectors of the community from the social, economic and political process of our socities. The political and social history of the popular movements has always centered on the constant demand for participation. One banner of participation has been in the political struggle. Another is the attempt to the attempt to open a space in which people gain a better sense of their own personal and social identity and also perhaps achieve some small solutions to the problems of their family or community.

Thus, the struggle for participation in health is twofold. It includes a demand for belonging, for being recognized and taken into account. And at the same time, it incorporates criticism of power and a demand for re-distribution. Both aspects can exist side-by-side with no great conflicts.

The starting point: participation or survival

Experiences of community involvement in health have a double origin. On the one hand, they are often initiated by a process that might be described as the external will, the ideas and projects proposals of non-governmental, religious and voluntary agencies. On the other side there is the need felt and expressed by popular groups who have been excluded from health services and deprived of resources to face the lack of heath and the deterioration of their living conditions.

Survival needs generate creative initiatives and constitute a permanent motivation to maintain, deepen and extend the services of a given program. This need has multiple expressions. In some cases it is the desperate need for health. It can be the demand for support and protection in the face of political repression. For many it is simply the grinding challenge to face, together the daily struggle for survival. The different contexts set in motion different mechanisms for solving problems. For each need there is a different kind of involvement.

Often there is no official health system and there are only the local resources (small programs and the community) to respond to the full range of health needs and demands. The result is that expectations rise and programs are caught in efforts to respond to particular problems and crises. Tensions increase under the permanent concern on the programs' part not to divert all action to the curative area. It is a constant challenge to maintain a balance between offering

health services and the commitment to education and promotion.

These tensions are only solved through the involvement of people from the community in the planning and organization of projects. Thus we heard how befor the project for the villages in the the San Jose de Catacaos Community *was written, it was discussed with the main leadership of the community. When they understood that the program was within the framework of popular education the leadership gave their consent. When the program started operating, the Community began to realize its importance in terms of mobilizing people. That's when they started to participate seriously. The leadership's view was that the Program should in fact be more directed to offering medical care and that this would help form a rapport with people who were still not taking part in the different community struggles and organizations. Thus they tended to criticize what was going on from the outside. The leadership also wanted to have a community health program that would link all the different villages.*

Through a long period of exchange and discussion the communities began to better understand what a popular health program could be. The professionals learned muc about what this type of program might mean to the community and how health was concretely linked to other issues. After many discussions, the following conclusion was reached: the program should be mainly educational, not basically of medical assistance but that a first-aid kit would be installed in the community center. This way the program would acquire visibility at the central structure level of the community. (CIPCA, Peru)

The following was agreed to as one of the final conclusions to our Montevideo workshop.

When facing health problems we discover a tension between satisfaction of people's immediate and urgent needs and the equally important need to promote solutions in terms of political changes. In this view, multiple tactics combine, which complement themselves simultaneously, placing emphasis according to the context and specific reality and in realtion to the process the groups are undergoing.

Involvement: a process

Each of the experiences presented in the workshop constituted an initiative and experiment in community participation in health. They represent different processes all aimed at creating new ways of promoting a collective and political view of health care. In this sense, involvement is not a model nor simply a perspective. It must also a method, a way of working, aimed at a specific and social and political vsion.

There is no question but that involvement is a process and as such is expressed in practice, through educational activities and the development of concrete actions. Thus practice and education are two fundamental dimensions of the same process and cannot be separated. Of course the unity and synthesis of these two aspects are expressed in different ways. For example, Vicaría Oriente *talked about how education is a permanent process that generates confidence and revaluation and that it is this process which makes participation possible. This type of educational work enables people to elaborate their own, autonomous answers for transforming their situation. The main objective is to promote active participation and to achieve greater autonomy on the part of the community regarding access to knowledge. Techniques used in the educational process allow the creation of a space where there is: participation, dialogue and solutions to concrete problems.* (Santiago, Chile)

If we analyze the actions undertaken by the different health programs we will discover how each is an exercise in team work and participation. Projects like an exhibition of medicinal herbs in the Tuxtlas community (Veracruz, Mexico) make possible and encourage the sharing of a common history, knowledge and health practice. In Barrio Sur in Montevideo the decision to investigate residents living and health conditions showed all involved that the experience of participating in a group could itself be therapuetic and a health-creating experience. They say *the group is curative and preventative in that it permits people to leave their confinement and tensions behind and to meet and share with others. It does not only talk about health; it*

generates health— at least for those taking part.

The list of examples showing how residents in neighbc urhoods or rural areas are organized and involved in research tasks, defining projects and putting into effect solutions for social transformation would be long.

This multifacet expression of participation—programs being born in the context of participation, learning through participatory methods, generating participation in small groups and local experiences—allow us to understand the real dimension and meaning of the demand for involvement by the popular sectors and non-governmental organizations. At the same time it raises greater challenges.

Different expressions of participation

One of the results expected from these experiences is the development of indigenous community organizations able to undertake health promotion and to provide some technical health support. This is of course a long-term objective and task.

Within the workshop we learned of several popular organizations in charge of health promotion and care in their respective communities. These differ according to the program's history and moment of development, according to the popular movement and to the living conditions and state involvement in health and the community.

It was interesting to note that the presence of promoters and the creation and involvement of health committees were common to most experiences. Promoters stand out as dynamic people who are essential to the development of the programs. They are considered the link and bridge between two cultures, between the community and the technical people. Although the title varies—monitor, health delegate, promoter—they constitute a major force in the programs of CIPCA (Peru), CLAEH (Uruguay), CIDEPSA (Peru) INPRODE (Chile), CINEP (Colombia). Most are women from the poor communities, between the ages of 18 and 45. They are housewives or students who see health workd as a way of extending their role as mothers and as a way of struggling for the survival of the family.

Training is considered as a key process through which it is expected that promoters will master basic technical-curative skills as well as develop themselves as educators and community leaders. Training is understood as a permanent process reinforced by daily practice. In the

program of San Jose de Catacaos Community, which has much experience in working with promoters, *they stress that promoters must know how to distinguish the most common diseases and their causes, and they must know how to explain these to the people and to look for organic, alternative solutions. They must also know how to promote and organize around health issues within their communities. The more we know, the better.* Here, as well as in the experiences of CLAEH (Montevideo), CIDEPSA (Lima), and UNIJUI (Brasil) the promoters themselves must also be able to train others. In this sense, the promoter is expected to be a community leader, always starting from the health needs and demands of the people.

The role of promoter is not an easy one. The accumulated experience of different programs with regard to the role of promoters has brought to light a range of doubts and criticisms, precisely because the promoter has been so central to strategies for alternative health programs.

The Centro de Medicina Andina *stressed that the role expected of the health promotoers role is not clear* (Cuzco, Peru). Questions emerge regarding the relationship of promoters to official health services, the community and the support program, the NGO. At the Centro de Medicina Andina we agree in theory about what the role of the promoter is, but in practice it becomes confused and contradictions emerge. *Theoretically the promoter is the link between the community and the program's health services. Essential to this link is the relation of trust based on the fact that s/he is chosen by the community. However, often it is not this simply: in many cases the election is not voluntary, but in response to the work and prodding of professionals. The promoter can come to be seen as distant from the community beccuse s/he is also part of the official system. After a while they start asking for a salary and monetary compensations. Professionals deny this, but the promoter feels an like an orphan to both systems. And oftentimes he or she ends up being used by both.* (CMA—Cuzco, Peru)
Unreal expectations by the community and program exagerate the crisis in the promoter's role and sense of belonging. CINEP and NUTRIR (Bogota, Colombia) define this clearly when they state *that promoters, who are women from popular sectors feel isolated, carrying out their tasks but unable to capture the full dimension of expectations. They want to be useful and to provide service, but too often they do not understand their work in terms of its organizational and political dimension.*

Many present in the workshop emphasized the need for groups and programs to prioritize the ongoing development of promotors and to provide promoters with forums for learning and

sharing with one another. This appears as a constant challenge: how to link and strengthen the relationship between local health experiences and community and political organization.

At the same time, it becomes urgent to study in depth: first, the promoters own motivations and expectations; and second, the issues of survival and remuneration for a service offered to the community.

Community-based groups or health committees: In some programs small popular health groups are formed, as a result of work experience with promoters; in other cases these committees have been part of the initial proposal. We are interested in highlighing the second alternative. Vicaría Oriente has had much experience in this. *Health community-based groups constitute the base of the program. They are formed by people from the poor communities who meet to learn and to look for ways to face, in an organized way, the health problems that result from the constant deterioration of their living conditions. They also organize to confront authorities with demands for services to which they are legally entitled.*

Analyzing the origin of these committees we find that while they respond to an external motivation (from the programs themselves, the church, a group of students, or whatever) their development is at the same time determined by the communities own needs and will. They often give the impression of being the germ of an organization, with their own capacity, which in time becomes stronger and more autonomous. They begin to request support from institutions in their own right. In fact these committees' potential lies in establishing themselves as popular groups, separate from the support insitutions and more directly linked to peasant or marginal neighbourhood organizations in their own sectors. Thus their identity lies in locating themselves at an equidistant point between institutions (NGO) and popular organizations (such as trade unions, marginal neighbourhood orgaizations, etc).
Nevertheless, this attribute does not guarantee their permanence or capacity to extend their work. Autonomy is not a solution in itself. The link with local organizations opens another space which has its own restrictions, given the nature and development of existing organizations. *Thus, at least as indicated in Peru organizational and community work is carried out with the community groups. But what presents difficulty is the weak organization of the community and the roles of the leadership people which often suibstitutes itself for the base* (CIDEPSA—Lima, Peru).

On the other hand, in dictatorships and repressive contexts like Chile, where health groups have been acquiring a particular identity, the problem can revolve around the question of

legitimacy. The community does see in these groups a possible source of support, but at the same time, the groups represent certain danger, that of organization and politics. Groups oscilate between being accepted and being rejected even though in the experiences presented all talked about how they experienced trust and acceptance growing, little by little, and over time. It is interesting to point out how this is achieved by means of concrete and visible activities that benefit the community, such as assistance to injured people in times of repression, educational programs, or campaigns directed at the control of contagious diseases and others.

For the health groups the experience of participatory training has been impotant. It is carried out in communities and is based on practice and concrete needs. In this way, action is repeated and the program is transferred to local everyday rhythms. We thus observe how the Health Committee of Barrio Peñarol (Montevideo) *develops a work program with neighbours and their organizations to confront common problems through participation, dialogue and discussion*. Another example is the popular committee in the Tuxtlas communities (Veracruz, Mexico).

Challenges that are posed to the health groups are not only of a technical, curative or educational nature. Their very existence implies their incorporation in social and political issues. To the extent that they are a new social force, they enter the dispute for hegemony among the different community and political organizations, many of whom are presenting different alternative visions of society. From the other side, they must also often confront health systems and NGOs which favour technical development and want to leave aside the political discussion.

Involvement or participation is not an aim in itself. Different experiences have pointed new directions and offered lessons; they have also opened up new questions, barriers and challenges. This was apparent as we shared and analyzed the different experiences represented in the workshop. We also found that important debates are still non-existent. This is the case with regard to the relation to the formal health system and state organizations. WHO for example promotes "associative collaboration." However entering this dimension depends on a very different political scenery than that present in many Latin American countries.

The wealth of practice and experience represented at this workshop lies in part in the fact that programs are working and struggling today to put into practice new visions of both "community" and "health." In their day-to-day efforts programs are pushing, and succeeding in extending, the boundaries of what is meant by "health" in Latin America.

5. EMERGING ISSUES

The exchange of experiences, together with the discussion about popular involvement in health, generated new issues for discussion and debate.

The contribution of popular education

Popular education was central to each of the experiences that we discussed during our days together. In many it provides the overall orientation guiding the work.

Education is a basic tool, a process that stimulates the development of individual potential. It promotes a critical perspective, in that it helps people understand the connections and societal roots of the problems they encounter in their daily lives. The educational component of our work is a permanent process, aimed at generating confidence, self-revaluation and participation. VICARIA ORIENTE - Santiago, Chile

From the moment community groups interact, the educational processes acquire special importance. The process of reflection-action and action-reflection allows for the gradual development of a critical conscience where the reality in which health technicians and community are located must be understood in its social, economic and political aspects, and not limited only to a narrow view of health. UNIJUI - Brasil

Pedagogical practice occupies a central place; it synthesizes the therapeutical and preventative approaches. It is a space where we regain lost parts of ourselves, and in this process remake ourselves as healthier human beings. INSTITUTO DEL HOMBRE - Montevideo, Uruguay

Education is the central factor in transforming people' s health situation. Popular eduation constitutes the conerstone for success. To start from the people, in terms of their consciousness and their naming of the problem, means to be committed to modifying the present health situation in line with the goals proposed by the group or community. CIDEPSA - Lima, Peru

The main axis of educational work is that people discover in the social structure the root of the their health problems and thus see

changes in health as related to the need to transform society. Tuxtlas, Mexico

The above represent overall orientations, important axes for our work. Yet beyond these, there remains a pressing need to clarify and refine concepts that will better guide our work in everyday practice.

We are deterimined to define clearly the steps involved in carrying out popular education in health. CESAP - Ecuador

We acknowledge popular education as a tool in carrying out health programs and in assuring participation. But, what do we understand by popular education? What are the contents and methodology we use?

We must start from the people's felt needs and move from there to the real causes. This is the core of popular education, which according to Paulo Freire should, **stimulate critical and autonomous thinking capacity but never remain at that. Educators must always start — the word is to *start*, not to *stay* — with people's own understanding and observation of their reality.** (R. M. Torres, "Educación Popular: un encuentro con Paulo Friere," 1986)

It is fundamental to recognize the relationship between the knowlege of different actors in health. This idea is particularly important when talking about health, where knowledge is a source of power, the power to decide, to cure, to look after life. This calls for radical change in health practices. It is very different to recognize when treating a patient, that s/he also has something to say regarding her or his situation, or, when working with a group, that the group has a creative capacity for problem-solving. This does not mean that such a relationship between subjects is built under the winds of ***non-directiveness***. Recalling Friere's words, **there is no non-directional education; the very nature of the education process implies direction.**

With respect to health, we are used to measurements and indications, and to a kind of evaluation that marginalizes the process itself on achievements. But in fact in many senses it is the process, the path along which education proceeds is more valuable than the results. When we evaluate our ***experiences,*** generally the achievements are located throughout, along the road of the process, in small and sometimes more spectacular intermediate results which often do not affect the formal health statistics directly or automatically. However, they may transform living standards, which can change health conditions.

To center ourselves in the process implies understanding that our small micro experiences are part of a permanent exercise of evolution and transformation. In short, this view is one that sees process as part of a practice of change, where educational as-

pects are political.

It is necessary to know and to use participatory techniques, creating new ones as needed. There continues to be a demand for tools, which in answering methodological criteria also facilitate the development of practice. Given the vast experience of isolated ***animation*** techniques, it is important that tools be developed that are clearly consistent with the overall orientation and political project of popular education. This raises once again the importance building strong bridges between our discourse and our daily practices, between our hopes and the instruments we use.

Participants in the workshop ***reaffirmed*** that the role tha popular education plays in health practices is to place our work within the perspective of social change, of seeking an analysis of the social and political causes of illness and of searching—beyond curing, reporting and preventing—to fight for a standard of living that allows for the development of all potentials of human beings.

While popular education provides health work a glimpse and goal of change, it also imposes in turn a daily path. It is an option for participation, mobilization and organization of popular groups. As part of this it implies alternative visions of the production of knowledge and of social transformation.

The relationship between micro and macro

This is a theme that has received a lot of attention. Certainly in Latin America there are many standard versions and emphases to the debate that have been accumulated over the last decade. Here we present a few of the key polemics presented in the workshop:

* **the challenge is to find ways of providing immediate answers to everyday health problems while advancing a process towards structural change;**
* **it is essential to favour democracy from the base and to recognize the weight of power relations within our programs, teams and communities;**
* **it is important to concentrate on the development of our micro experiences and at the same time to insert ourselves into global social policies.**

These dialectic "confrontations" often present conflicts in our work, with discussions and practice leaning to one or other of the poles at different times. Thus in the workshop, our discussion was at first centered around the issues of health and politics. Participants emphasized the need to link local work to an option for structural change and the importance of seeing popular education as a process of transformation of learners into politically active individuals and not simply more knowledgeable consumers of health services. In this context, educators have multiple responsibilities. They must not only have an understanding of health and education, but also of politics. Educators are called on to contribute to political and social transformation. The challenge is to invoke an awareness of the small and positive experiences that are being developed at the local level (in organizing, in health, in communities) but at the same time to find ways of linking these to more global attempts at change.

Later, when this discussion was presented at the workshop's plenary, the focus shifted to the other end of the dialectic, to the problems and limitations of past efforts at national political projects for change. Participants reaffirmed how in the micro world it is possible to face more personal relationships, also very important for social change. This debate lead us to underline the importance of responding to the reality of (and problems associated with) the presence of power relationships in the different dimensions of everyday life. In this sense, the discussion clarified how the transformation of relations of domination—at an everyday level—into equal relationships is in itself a political task.

Undoubtedly, our health experiences are primarily located in this local (micro) di-

mension. Our overall propositions, beyond the call to structural change, are weak. This fragility is a product of the Latin American political reality, where today we do not find it easy for new dreams or hopes to arise. Hence our persistence in centering our energies on small local experiences, except for scattered efforts at regional or national coordination and networking, for example in Uruguay, Chile, and Brazil, that help break the marginalizing silence that many groups experience.

Despite our localization, participants were unanimous in their belief that there can be no committed micro experience that is not oriented by a deep and radical macro impulse. In one way or other, these two intensions are, as one compañero indicated, "the two faces of our everyday work."

In practice, there are visible experiences of articulation between the two, as in the case of non-governmental health centers in Lima, which at a given political moment had to pull down their walls and work together to formulate overall health strategies. They demonstrated that the challenge is also to be able to work together at a macro level, while maintaining the strengths of local practice. There are still no clear paths to follow, only a few traces rich in collective experimentation. Thus there is a need for a constant rethinking, analyzing, learning and re-trying.

In summary, participants recognized the need for a strong and constant correspondence between small, personal and private actions—those in the ambit of everyday life—and the need for mobilization for structural changes. This articulation goes through and must be nourished by personal transformation at an everyday level.

The contribution of traditional medicine

The subject of traditional medicine wound through our discussion and propositions. First, the Centro de Medicina Andina presented its analysis and experiences in Peru's southern Andean region. Other participants contributed their experience and criticism of Western medicine, particularly its commercial side. The constant search by all groups for popular and innovative alternatives definitely opens the field to new perspectives in health work that incorporate the richness of traditional medicine.

In the view of the Centro de Medicina Andina, *health care is doomed to failure as long as we don't understand the current and potential contribution of traditional medicine.* At the same time, they reminded us that learning from and incorporating *traditional medicine practices is a complex task. There are as many systems of traditional medicine as there are existing cultures.*

The search to incorporate this cultural root arises from an urgent need for a better convergence between communities and professionals in planning health activities. There are plenty of examples reporting errors and missing links. In Peru, as one friend recounted, they decided to approach the problem of TB. They brought experts from other countries, they bought microscopes and spent a lot of money implementing the program. But the results were negligible. Where does the error lie? Was TB the problem as far as the community was concerned? Why wasn't the program well received by the community? Did the community have different priorities from the professionals? Were they asked? Programs must make decisions considering community problems as they are experienced in the life of the community, and these must reflect the community's culture, their needs, and priorities and they must use methods accepted by them when confronting different problems.

It is only in the recent past that traditional medicine has once again become accepted as important in dealing with people's everyday medical problems. According to CMA's *analysis traditional medicine is gaining credibility because of the inability of the Western system to solve health problems, in part as a result of lack of resources allocated to health care for poor sectors. This raises a new contradiction. Reliance on traditional medincine is a convenient way of filling gaps in a deficient system; it doesn't necessarily imply a revaluation of the traditional system or a deep questioning of Western medicine.*

To the extent that the interest of people like those taking part in the workshop centers on

revaluation of traditional medicine, the field is open to a search for its positive components. This perspective emphasizes its causal and humanitarian perspective, its reading of illness as not limited to "problems," but as located in the patient as a whole person. A traditional approach integrates pain and the person into the community, through answers and cultural demonstrations, between rites and signs, between its affective and mystic aspects.

The richness and potential of traditional medicine was recognized by those participating in the workshop, *and thus the challenge was posed of continuing to research its components, its inherent opposition and/or possible integration with prevailing practices. The importance of its inclusion in popular health alternatives was shared by all.*

The role of technicians and professionals

Many of the participants started their work in this area as professionals, and within the official system. It was with from that base that most started to accumulate a first-hand criticism of technical and professional roles. With this first questioning, we became involved in popular work, searching to build more democratic and non-authoritarian re-

lationships. Much of the criticism we accumulated concerned the arbitrary common use of power by medical professionals, their bureaucratized practice and through that the marginalization of popular culture. It was recognized that the response of some health workers was to go to the other extreme of complete non-intervention or passive acceptance of the knowledge and action of popular sectors.

There was an important moment in workshop when participants explored our personal links, as professionals, with health issues. This was done through an imagery technique which prompted us to reflect on and share why and how we became involved in health issues. *It was important to see the different reference points in our past lives that prompted our decisions to take up work in health.* Through this it became clear that for many the choice and practice had a very individual starting point.

The point of beginning to work collectively to solve health problems was another key moment for many. As one participant expressed it, *we failed in our work because we have no exerience as a group. We were trained as individuals. Thus it is urgent that we feel we are a group, that we share our needs and that, starting from this perspective, we work for social and political participation and mobilization.*

That moment of introspection sensitized the personal contact and reestablished communicaion links between all the participants. The experience created a special concern regarding our relationship as professionals with popular groups.

In regard to this theme, the workshop debate shifted from one day to the next, and crossed all other themes. In the end we tried to synthesize different conversations and concerns. There was unanimity that the work with popular sectors demands a radical relearning, that must permit locating the contribution of professionals not only in academic terms but also squarely within the vision of strengthening popular participation. This option implies recognizing both the differences between popular groups and professionals and the possibilty of a common field of interest and action that exists. In this coming together, both professionals and grassroots sectors learn mutually, they advance in producing a knowledge of reality. It is in this process that both can work together in a transformation process.

Second, the debate in the workshop underlined the different dimensions of health practice, recognizing that technical, affective and political aspects can converge. This distinction facilitates the understanding of the nature of the insertion of professionals in popular programs and the need to face—

sometimes simultaneously—the different challenges.

The conversation on this subject ended by recognizing professionals as actors with a specific role, which is at one and the same time personal, technical and political. This is the challenge posed to professionals to take up this role and to insert ourselves in a process of professional re-education and strive to develop participatory alternatives in health programs that will change the relation between "technician" and "patient".

Final propositions

The discussion of these themes in small groups and then in the plenary helped us clarify old questions and at the same time raised new doubts and challenges which were presented to the final assembly.

* **Popular health experiences encourage the development of popular organizations and at the same time help broaden and strengthen their horizons.**

  Some experiences are assumed autonomously by popular organizations; others work at the level of the local community; others establish sectoral coordination or exert pressure on public administration organizations (the state or others).

* **In facing health problems we can observe a tension between the satisfaction of people's immediate and urgent needs and a commitment to structural change. In this view, multiple tactics are combined which complement each other simultaneously, emphasizing different aspects according to the context, specific moment and the process the groups are undergoing.**

* **In the face of the domination of a medicine that divides and tears human being apart, there is a search for health practices that understand people as whole in relation to nature and their cultural-political context.**

* **The role that popular education plays in health practices is to place this work within a perspective of structural change, of analysis of the social and political causes of illness, searching not only to cure, to inform and to prevent, but to fight for a standard of living that allows the development of all the human beings potentials.**

  In health work, the path and process are just as important as the results. Within this perspective, participatory techniques are a valuable contribution if they are

incorporated within the aforementioned intentions.

* It is important to recognize the need for a constant linking between small, personal and private actions—those located within the ambit of everyday life —and the need for mobilzation for structural changes. This link is urgent, as structural transformation goes through personal transformations at an everyday level.
* In capitalist countries, people's therapeutical need has been transformed into a commodity. Thus, the knowledge, training and practice of health professionals reproduce relationships of authority, power, and control of diseases in order to maintain life only in relation to maintaining a productive work force.
* We propose a search for alternative health practices which, encompassing the overall vision of men and women in traditional medicine, will integrate modern knowledge to the service of the people.

The convergence of popular education practices and the search for new alternatives in health care, assure that we are advancing towards the construction of the vision and understanding of health that we need.

APPENDIX

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